California Cancer Commission Studies*
Chapters XIII and I-A

Cancer of the Tonsil and Pharynx

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ACUMEN in diagnosis is not a heritage, it is the result of clear thinking and constant attention to details. Each patient who comes to a physician is entitled to the best. Therefore the time and effort spent in preparing these few pages was with the hope that the reader would be stimulated and encouraged to do two things. First, to review mentally the cases of cancer of the tonsil and pharynx he had seen, the ultimate outcome of them and the responsibility for that outcome; second, to encourage physicians to maintain the highest standards of diagnosis for such cases.

CANCER OF TONSIL—SYMPTOMS

Cancer of the tonsil is rare. Unfortunately its early stages are often relatively asymptomatic, and *the usual symptoms are only those of a feeling of discomfort, or unilateral tonsillar enlargement, or a sense of local irritation.* This lack of subjective symptoms often persists until the tonsil and even the surrounding tissues are replaced by a fungating, ulcerated mass that has gross metastasis as evidenced by enlarged, hard, cervical lymph nodes. *Pain is usually a late symptom* and its presence depends on the proximity of the lesion to an important nerve trunk.

DIAGNOSIS

All too often the patient with a complaint of tonsillar irritation receives only a cursory examination. As a result it is not realized that there is an asymmetry or that the tissues surrounding a tonsil crypt opening are indurated or that a tonsil tag does not appear normal. The patient is dismissed after a "throat swabbing" and with a prescription for a gargle. A few months later the diagnosis is all too evident because of a large ulcerative mass and metastatic lymph nodes. It is only then realized that cancer was the cause of the asymmetry or irritation. Unfortunately the chance of cure is usually gone by then.

Adequate inspection of the tonsillar area is not difficult and does not require special instruments. A tongue blade, flashlight and finger cot are all that is needed. If there is a hyperactive gag reflex, there should be no hesitancy in applying one of the effective topical anesthetics. One very valuable procedure almost always omitted is palpation. The visual examination may reveal no asymmetry or apparent change from the normal. *Digital examination* will often reveal differences in tissue density and will give one a rough idea of the extent of invasion of a cancer.

Diagnosis is always by microscopic examination of a biopsy specimen. *The presence in a tonsil of a mass, or an ulcer, or of an area of tissue that feels different than the surrounding tissues demands immediate biopsy.* If the involved area is confined to the tonsil this can be done by tonsillectomy. When this is not feasible, representative portions of the involved area should be removed. In either event all the tissues removed must be submitted for pathological examination. A negative biopsy does not mean "no cancer"; it means "take another biopsy." It is wise when doing tonsillectomies in adults to submit the tonsils to a pathologist for at least gross examination.

TREATMENT

Cancer of the tonsil is seldom, if ever, recognized early enough to permit any assurance that it has not metastasized to its tributary lymph nodes. This being the case, *simple tonsillectomy is never sufficient,* even though the pathological examinations show a wide margin of normal tissue. *Adequate radiation therapy is essential* in even the earliest cancer of the tonsil and must be directed to both the tonsillar area and its tributary lymph nodes. To omit radiation therapy is to deny the patient a chance for a cure of the cancer. Accepted radiological practice for these lesions consists of daily doses of x-ray to the involved areas, to full tolerance of the tissues. In selected cases this should be supplemented by interstitial radium or radon.

Advanced lesions with evident metastasis should never be subjected to operative procedures other than a biopsy for diagnosis. Extensive x-ray therapy is the only method of treatment for such cases. The prognosis in such cases is bad.

CANCER OF THE PHARYNX

The pharynx conveniently divides itself into three divisions, the nasopharynx, oropharynx, and hypopharynx. The oropharynx is the only one of these easily examined by direct vision, and is singularly free of cancer.

The nasopharynx and hypopharynx are readily inspected by the indirect method wherein one uses a head mirror as a source of reflected light and a laryngeal or pharyngeal mirror for reflecting the

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image. Technical details of this examination are readily mastered. Facility in the use of these instruments, in the understanding of mirror images and in differentiation between normal and abnormal findings comes with practice. Only by making this procedure routine in all physical examinations can one become facile at it and acquire a clear mental picture of the variations that constitute "within the limits of normal." In these areas, as elsewhere, palpation can and frequently will reveal important information. The gag reflex is a great nuisance but will readily succumb to local anesthesia.

NASOPHARYNX

Cancer of the nasopharynx is especially insidious and the lesion frequently causes no symptoms. This makes it imperative that every doctor learn to do adequate nasopharyngeal examinations and that he include them in his routine physical examinations. In some cases, pain or discomfort in or about the eye or ear will be an early symptom. Persistent pain along the distribution of the first and second divisions of the fifth cranial nerve necessitates a careful examination of the nasopharynx. All too often the cervical masses of metastasis to the lymph nodes are the only symptom that sends a patient to his doctor. This lesion has a predilection for Chinese in the ratio of 14 to 1.

The metastatic masses frequently are out of all proportion to the initial lesions. The primary lesion is often found only after diligent search of the nasopharynx and numerous biopsies of all suspicious areas. *Nasopharyngeal cancer is the most common, non-apparent primary tumor, responsible for cervical metastasis.* These tumors spread early and rapidly, invading extensively locally, as well as spreading to distant areas. In all cases basal skull films are indicated at the time of diagnosis. Whenever there is unilateral cervical adenopathy, the nasopharynx always should be carefully searched.

Operation is of no value. An adequate course of radiation therapy is the only form of therapy that can be advised. The number of reported five-year cures is so small that one must conclude that therapy is essentially palliative. However, the fact that there are some cures makes it imperative that all cases receive intensive radiation. These tumors are very radiosensitive.

OROPHARYNX

This area is seldom the site of a primary neoplasm. Occasionally one finds a pedunculated papilloma or fibroma, islands of hypertrophied lymphoid tissue or a mucus cyst, but rarely a cancer. A mixed tumor of a minor salivary gland is very rarely found in this area. The oropharynx is frequently invaded directly by cancer arising in the nasopharynx, tonsil, base of tongue, or hypopharynx. Thus almost invariably, a visible tumor of the oropharynx is either benign or a sign of late cancer in an adjacent area.

Tertiary lues may produce a nontender swelling on the posterior pharyngeal wall. If untreated it will break down and produce a characteristic stellate scar. "Cold abscess" from tuberculosis of the cervical spine or deep lymphatics usually presents on the lateral and posterior walls. Occasionally one finds a residual tumor mass following incomplete resolution of a retropharyngeal abscess. Exploration will show semi-inspissated or caseous material, evacuation of which leads to prompt recovery.

One word of warning! Do not attempt to remove, explore, or biopsy any pharyngeal mass until you are certain it does not pulsate. The pharynx contains large blood vessels that do not always follow textbook illustrations.

HYPOPHARYNX

This area does present an occasional benign tumor, such as a lipoma, fibroma or papilloma. Cysts of the epiglottis, glosso-epiglottic fold, and around the foramen cecum are rare but must be kept in mind. Their treatment is surgical removal.

Cancer of the hypopharynx is not uncommon. The greatest percentage is of epithelial origin and is therefore carcinoma, usually of the squamous cell type. Lymphosarcoma is less frequently encountered.

Any complaint of pain or discomfort in the throat, of dysphagia, or of a burning sensation, especially if these are associated with pain radiating to the ears, demands careful examination of the hypopharynx, before the patient is sent on his way with a diagnosis of neuritis, neuralgia or globus hystericus. The examination should include visualization of the base of the tongue, pyriform sinuses, ary-epiglottic folds and epiglottis. This is usually done with head mirror and laryngeal mirror. Topical anesthesia is a valuable aid to securing adequate visualization. There should be no hesitancy in using a finger to palpate suspected areas. Where doubt exists, one should resort to direct laryngoscopy.

The commonly accepted method of treatment for cancer of the hypopharynx is a full course of radiation therapy. Attempts at surgical removal of cancer in this area have been generally unsuccessful. The operative mortality is high, and there is frequently local recurrence. Early lesions of the epiglottis, especially if confined to the upper half, may be treated surgically.

SUMMARY

Cancer of the pharynx or tonsil is not rare. In the early stages its symptoms are very minimal and frequently are only mild, persistent soreness, a burning sensation, mild dysphagia, slight "stuffiness" of the ears, or some similar complaint. Such complaints require careful examination of the entire pharynx, using a head mirror, pharyngeal and laryngeal mirrors and the finger. Any small ulceration, projection or tumor, or area of changed tissue density, should be biopsied. Not infrequently these patients present themselves with an initial complaint of a "neck tumor" due to cervical lymph node metastasis. In any case of unilateral cervical adenopathy careful search of the pharynx for a cancer is a *must.*

In general, malignant lesions of the tonsil and

pharynx have a low five-year survival rate in spite of intensive treatment. This is because the diagnosis is seldom made when the cancer is in its early stages. Good results have been and will be obtained in early cases treated *adequately*. Good results cannot be expected in this or any other cancer, when therapy is instituted after metastases have appeared. Delay in diagnosis assures a fatal outcome. Neither you nor your patient are entitled to temporize with a condition that could be cancer. The patient's entire future depends on your making an early, correct diagnosis and seeing to it that proper therapy is started at once.

"Cancer of the Larynx," by Simon Josberg, M.D., Chapter XIV of the California Cancer Commission Studies will appear in this section of the March issue of CALIFORNIA MEDICINE.

The Responsibility of the General Practitioner in Neoplastic Disease

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THERE is no difference in respect to the practitioner's legal duty to a patient with neoplastic disease than in any other case. When the physician undertakes to render professional services to any patient, he assumes certain legal obligations. He must possess the degree of skill and knowledge commonly possessed by other reputable physicians in the community; he must exercise a degree of care, diligence, and judgment equal to that of other practitioners who engage in treating similar cases; and he must keep abreast of progress in the profession, utilizing accepted and standard procedures in diagnosis and in treatment.

The relationship of physician and patient is one of trust and confidence, requiring that the physician act at all times with the utmost good faith toward his patient. This demands for example: that the attending physician, if he doubts his ability to care for a particular case, must so inform the patient; and that, if he feels that a consultant would be of benefit, he must so advise the patient or he must call in a consultant.

The attending physician must act, at all times, in a manner consistent with the standard of practice in the community. The standard of practice is established by what the ordinary, reputable physician would do and what he would refrain from doing in the care of a similar case.

The standard of practice applies to diagnosis as well as to treatment. If the ordinary practitioner would, in the face of a particular case, utilize certain procedures, x-ray, biopsy, etc., the standard is thus established in that type of case. And standard procedures must be followed if the physician is to avoid a legitimate charge of malpractice in the care he renders to a case of that particular kind.

There is being manifested in this locality an increasing interest in, and attention to, the problem of cancer. The lay group are being impressed with the importance of early diagnosis in cancer. If there is apparent delay in diagnosis, or if there is a failure to take advantage of facilities provided, there is likelihood of suit.

For illustration, we have recently had a case wherein a patient, complaining of relatively vague digestive tract symptoms, was carried along without an x-ray examination and without definitive diagnosis for 15 months. The patient then presented a massive carcinoma of the stomach with metastases. It is not unlikely, in such circumstances, that a court would find against the physician-defendant. In another case, a physician "awaited developments" when a woman of about 45 presented a small mass in the breast. This was unfortunate for the patient and eventually for the physician.

There is no doubt but that the practitioner can immeasurably safeguard himself, by making use of the nearest tumor board, whenever he has a patient who may have neoplastic disease. If there is the slightest doubt in the physician's mind, and he is not able to assure himself that the patient does not have cancer, then he should protect the patient and safeguard himself by taking advantage of the consultative facilities which are available.

The people of California's communities are becoming informed of the existence, purpose, and method of functioning of tumor boards and detection clinics. The fact that many of our physicians are utilizing these facilities in connection with their doubtful or problem cases, is tending to establish their use as being within the standard of practice. It must not be forgotten that the failure to render care consistent with the standard of practice constitutes malpractice, if the patient thereby suffers injury.

In the past the majority of malpractice claims associated with cancer cases have been based upon the allegation of x-ray injury. In the future, it is readily foreseeable, there will be more suits based upon the claim of failure to diagnose, or delay in diagnosing, an existing malignancy. If there has, then, been a failure to make use of facilities, about which even the layman is informed, it must be anticipated that that failure in itself will almost be regarded as prima facie negligence on the part of the attending physician.

It is well known that malpractice claims are not uncommon in California. A physician is unwise indeed who, in this area, does not take positive steps to keep himself out of court.